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THE IMPORTANCE OF LABORATORY DIAGNOSIS.

DR. H. MILTON CONNER, Topeka, Kansas.

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In this day of progress in medicine when it is charged by many that the practice of medicine has "gone to seed" on laboratory diagnosis, it may seem to some, useless to read a paper, further calling attention to, and emphasizing the value of the clinical laboratory.

But I, in common with many others, am so impressed with the value of this most important aid to diagnosis, that I cannot but feel that it cannot be too forcibly emphasized.

To begin with, let us consider a few conditions in which the laboratory examination of the urine is essential.

Altogether, the urine is far more frequently examined in the laboratory than any other secretion, excretion or body fluid or tissue, but still far too infrequently by a large number of us. Too, when it is examined, reliance is too often placed on the chemical examination only, neglecting entirely the microscopical side of the work. I think that if we had only the one method of examining the urine—chemical or microscopical—that in disease of the urinary apparatus, the microscopical examination would be of the greater value in diagnosis.

How can the clinician make the distinction between diabetes mellitus, that most dreaded disease and diabetes insipidus or polyuria from some other cause, except by means of the urinary examination? How many cases of chronic interstital nephritis with the passage of large quantities of urine of low specific gravity have been treated for diabetes insipidus or hysteria? In this case more than a chemical examination is required, for unless albumen appears in appreciable quantities in the urine of the

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victim of interstitial nephritis—as it very frequently does not—then the diagnosis would be at fault from a chemical examination only. The history of the case with the heightened arterial tension and stiff vessels, in conjunction with the laboratory examination, showing hyaline and granular casts, low specific gravity and the presence of albumen, sometimes only the merest trace, clinches the diagnosis. How many cases of lumbago have been diagnosed and treated for kidney disease, when an examination of the urine would have shown the absence of the latter complaint?

Again, we see cases of cystitis called kidney disease, on account of the reliance on the chemical examination only. We may find albumen in the urine of a severe cystitis, from the purulent exudate, but a microscopical examination will usually clear the situation by the failure to find casts and kidney epithelium in cystitis.

Examination of the sputum and swabs from the throat are also of very great value. What progressive physician attempts to make a certain diagnosis between a streptococcic and diphtheritic pseudo-membrane without a laboratory examination? What conscientious practitioner attempts to make a positive diagnosis of tuberculosis of the lungs, without an examination of the sputum? We all know that formerly many cases of chronic bronchitis were called consumption, and vice versa.

The stomach contents are far too infrequently examined in the laboratory. Many cases of carcinoma of the stomach are diagnosed and treated for chronic indigestion, when an examination of the stomach would reveal in a large percentage of cases carcinoma, the absence of free hydrochloric acid, with the presence of blood, lactic acid and the Oppler-Boas bacillus. The distinction between ulcer and carcinoma of the stomach or ulcer and gastric neuroses can also best be made by the laboratory examination of the stomach contents.

Probably one of the most neglected excretions from the laboratory standpoint is the feces. This may be partly accounted for by the disagreeableness of the work, but partly also because we are likely to feel that the examination of the feces is not of much value. The truth is that it is very important.

Many times, blood can be detected in the stools in cases of carcinoma or ulcer of the stomach, when it cannot be found in the stomach after several examinations.

Much can be found out in regard to the efficiency of the digestive process, by an examination of the stools. If large amounts

of starch or fat are found constantly, we have reason to think the digestion of those substances is faulty, and act accordingly.

The presence of the typhoid bacillus in the stools of typhoid fever, the bacillus dysenteriae in bacillary dysentery, the entameba histolytica in amebic dysentery, the bacillus tuberculosis in intestinal tuberculosis are only a few examples of the diagnostic value of the laboratory examination of the feces.

The microscopical examination of tissues is also of the highest value, both for diagnosis and prognosis.

We all know that a considerable number of cases of carcinoma of the uterus are sacrificed every year, whereas, an early examination of curettings, or a piece of tissue excised for the purpose, would enable a diagnosis to be made in time for a successful operation.

Again, many cases of malignant growth of other regions could be diagnosed in time for successful treatment, if a piece of the tissue were excised and sent to the laboratory.

However, the suspicion of malignancy is not the only reason for having tissues examined. I have in mind a case of a small oval body about one by one-half inch, apparently a tubercular lymph node, removed from the cervical region, which was sent to me for diagnosis by one of our surgeons. It was full of cheesy material, such as is found in tubercular lymph nodes that have undergone softening. An examination of the semi-fluid material was made for tubercle bacilli, but none were found, as frequently happens in the so-called pus in tubercular lesions. Sections were made and presented no evidence of tuberculosis but the entire cavity was lined with a stratified squamous epithelium, and the diagnosis of branchial cyst was made. In this case the prognosis, subsequent treatment, etc., depended very much on the laboratory diagnosis.

In all cases of a suspicious lesion of the breast, uterus, face, lip, tongue or any other easily accessible organ, a laboratory diagnosis should be made, and the treatment based very largely on the findings of the laboratory.

Of course, this usually necessitates the sending of the specimen to some diagnostic laboratory, as the average man in general practice hasn't the time to devote to this line of work, even though he were equipped with microscope, microtom, and other necessary apparatus and reagents. Besides, this work would come so infrequently in the practice of the busy physician, that he would not feel capable to interpret the findings unless he were specially equipped in this line.

One of the most neglected, but important fluids of the body, from the standpoint of laboratory diagnosis, is the blood. Although a large amount of work is done in this line, still it is not nearly commensurate with its importance. Since the examination of the blood has become a matter that is resorted to by almost every progressive physician the term malaria has ceased to be the dumping ground for our inability to make a diagnosis. The term typhoid malaria has also ceased to be the scapegoat of poor diagnosis because the doctor knows that someone else may come along and do a Widal test or examine for the plasmodium and show the incorrectness of his diagnosis.

The primary, or essential anemias, have been separated from those due to other diseases, otherwise called the secondary anemias and the prognosis and treatment regulated accordingly. A certain diagnosis of chlorosis, pernicious anemia, or the leukemias, can be made only by means of the laboratory, in conjunction with the clinical examination. When we remember the great resemblance of the gross lesions that are apparent clinically between leukemia Hodgkin's disease and tuberculosis of the lymph glands, we cannot fail to recognize the value of the ability of the laboratory to make a positive diagnosis of leukemia.

Again, certain diseases, clinically very much alike, can very frequently be distinguished by the presence of leucocytosis in one and its absence in the other.

The prognosis in some diseases, such as lobar pneumonia, can be obtained in many cases from the leucocyte count. The distinction between bronchial, and renal or cardiac asthma, can often be made by the differential leucocyte count, the former condition showing a marked eosinophilia, while the others show no characteristic change.

The Widal test for typhoid of course, needs no mention, as it is recognized by almost all phyiscians as of the greatest value in diagnosis. Another method of diagnosis in typhoid that may be done much earlier in the course of the disease is a culture of the bacillus obtained from the blood.

We might enumerate a very large number of diseases that may be diagnosed, or at least an aid to diagnosis obtained, by examination of the blood, but those mentioned ought to serve the purpose of emphasizing the value of its examination in any obscure case, and in many cases apparently clear clinically.

But probably the most important procedure in the examination of the blood is the Wasserman test for syphilis. I say most important, because it is one of the most accurate methods of

diagnosis in medicine to-day. A positive Wasserman reaction is almost certain evidence of syphilis, barring a few diseases such as leprosy, scarlet fever, frambesia, trypanosomiasis and possibly malaria, which in most cases are not likely to be confused with syphilis anyway. To emphasize its value, I wish to report a case of peculiar clinical value on account of the very typical symptoms, and one which emphasizes very strongly the value of the Wasserman test. Mr. B. developed a small sore on the penis two weeks after exposure. A week later, he went to a physician who consulted me in regard to the advisability of a Wasserman test. I told him that a Wasserman at that early stage would probably be of little value, as it would almost certainly be negative in so short a time after the appearance of the initial lesion. However, the patient insisted on a Wasserman a few days later. This was negative. The chancre could not be examined for the treponema pallidum, as it had been cauterized by the patient himself. In the course of six weeks, the sore was healed perfectly and no further manifestations were seen except a slight enlargement of the inguinal glands, which, however, he insisted he had always had. Six weeks after the first Wasserman, I did another, which also was negative. Careful watch was kept for the secondary manifestations, but none appeared—no skin eruption, mucous patches, headache, falling of the hair, pain in the joints, or any other of the secondary symptoms—except a slightly suspicious throat. Two months after the second Wasserman, or four months after the beginning of the disease, I did a third Wasserman. This time it was distinctly positive, notwithstanding the fact that there were almost no clinical manifestations and certainly none on which a diagnosis of syphilis could be based. The diagnosis by the Wasserman test was proven to be correct in this case by the fact that the patient could take five grains of the protoiodide per day without manifestations of mercurial poisoning.

Many other cases could be cited which would show the very great value of the Wasserman reaction, but this case serves the purpose. In fact, it is so valuable that nearly all of the men who are giving salvarsan extensively, are doing so only after a positive Wasserman, and also doing a Wasserman, or a series of reactions, as a means of control. A persistently negative Wasserman test when all the clinical symptoms have disappeared, is the only safe criterion by which to judge, whether or not, the case is cured. A positive Wasserman, even when the symptoms have all disappeared, is the signal for further treatment. A great deal of discussion, in regard to the Wasserman test's being non-speci-

fic has taken place, but this does not detract from its values as a diagnostic agent. It is still by far the most accurate method of diagnosis we have, and should be resorted to in every case. Practically every case of untreated secondary or tertiary syphilis reacts positively. Of primary cases, about sixty per cent. react positively. Consequently at the time when the diagnosis is most obscure the Wasserman test is almost absolute when treatment has not been administered. Where treatment has been administered in cases of syphilis, it also reacts positively in a great majority of cases.

The great disadvantage of the Wasserman test is the fact, that on account of the large amount of work connected with it and on account of the laboratory animals required, it cannot be done by the busy doctor in his practice, because he would necessarily have to refuse other business while he is doing it, consequently it will probably never be done very extensively by the general practitioner, but will be left to the laboratory worker.

In conclusion, I wish to again urge upon the profession, the great value of the diagnostic laboratory in all of its phases, only a few of which, I have discussed.

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MEASLES—A SERIOUS DISEASE.

LLOYD A. CLARY, B. S., M. D., Elbing, Kansas.

Read before the Marion County Medical Society, March 13, 1912.

Measles is a disease that we are too prone to ignore, one that we are apt to class among the mild children's diseases and to speak of lightly, as being of slight importance. It is a disease that we, even though we are supposed to be medical men and to know something about it, are very likely to look upon as a joke. Because measles is decidedly no joke, but a dangerous disease, serious in its complications and sequelae, I have taken it for my subject believing it a topic worthy of discussion.

As to the cause of measles we all know that there is a specific virus that causes the diseases, but just what this virus is and what name we shall give to it is still in doubt. There has been a lot of work done during the past year, on this subject, a number of experiments having been conducted by Anderson and Goldberger working in the Hygienic Laboratory of the United States Public Health and Marine Hospital Service in Washington. Among other things they have given us some information on the filterability, resistence to heat, drying and freezing of the virus of

measles, but they have not isolated this virus sufficiently to determine just what it is. It is probably a micrococcus.

The infectivity of measles is well known, but just how virulent is the virus of measles is still a disputed question. Anderson and Goldberger, in the experiments above referred to, demonstrated the infectivity of measles among monkeys by "contact." They also clearly demonstrated that the mixed buccal and nasal secretions were infective on the 4th and 6th days of the disease, and that this infectivity was due to a living virus susceptible of transfer from monkey to monkey by blood inoculation. These experiments, carried on during June and July 1911, are claimed to be the first that convincingly demonstrate the virus of measles in buccal and nasal secretions. These experimenters show that the blood of measle patients loses its infectivity about 24 hours after the appearance of the eruption and that the blood is infective from just before until 24 hours after the eruption. They have shown that the combined buccal and nasal secretions are not infective in all cases. It also seems from their work that the scales are non-infective, this latter point having been claimed before by a number of investigators. We may draw the conclusion from all this that measles is an infective disease and that the patient should be isolated, and that the secretions from nose and mouth especially, should be taken care of to prevent the spread of the disease.

Right here it might be of interest to remark that T. J. O'Meara, in the Medical Press and Circular, London, for Sept. 6th, 1911, says that immunity against the toxemia of measles is gradually acquired in insular communities where isolation is practiced. This is shown on Cape Clear Island. He points out that the course of the disease during the past thirty years shows this immunity is hereditarily acquired, the death rate having fallen in proportion to the percentage of parents who had measles before marriage.

In measles one attack does not afford immunity, as many as four attacks having been recorded in one individual.

As to the pathology of measles. In uncomplicated cases we have no pathological lesions. The only post-mortem changes found, as a rule, are those of catarrhal pneumonia and acute nephritis. However, all the internal organs are gorged with blood, minute hemorrhages are found on their surfaces and croupous pneumonia may be found involving a portion of a lung. We see from this that something has taken place within the body that is

not natural and it should lead us to regard this affection as a disease of some consequence.

The diagnostic points in this disease are: or should be, so well understood, that they require no discussion. When found in typical form it is comparatively easy to diagnose, a simple glance at the patient often sufficing to tell the experienced practitioner what he has to deal with. The symptoms of a "cold," a dry, metallic cough, the coryza, slight fever, photophobia, and the eruption itself, starting on the forehead and neck and spreading down over the body, forms a picture generally easy to recognize. Koplik's spots, which are reddish papules with a peculiar bluish-white speck in the center of each and which appear on the buccal mucous membrane or soft palate, are of great diagnostic value. They can be seen only in daylight, and for this reason we many times do not find them on our first visit. Still, it is not hard to make the diagnosis of measles provided the case is well marked. But sometimes we have measles associated with chicken-pox or scarlet fever and then the task is not so easy. As they are all diseases which should be quarantined, however, we can at least do that much to protect the community while finding out just what name to apply.

We are not going to attempt to describe the clinical course of a case of measles. Every physician knows, or should know, all that is necessary regarding this phase of the subject, We expect to take up the subject of complications and try to bring out the fact that measles is serious and should be so regarded.

We have heard physicians laugh about measles and say that the disease did not amount to much and that there was no use to quarantine the patients. We have also heard mothers say that they did not care if their children did take the disease as they were almost sure to have it sometime or other and had better have it while young. They even seemed to place their children in the way of those already infected so that the children would catch it and thus get the thing over with as soon as possible. Now on the part of these mothers we can blame them very little. But the doctors who carelessly let measles spread and who make light of it are doing that which they should be ashamed of and which is little short of criminal. How often we hear someone say: "Yes, my sister is hard of hearing. She has been that way ever since she had the measles."

This thing is too common. You have all seen and heard it. There is no excuse for it except ignorance. We must realize that measles is dangerous and we must impress upon the laity if we

are to do away with all the wreck and ruin that is sure to follow measles. When people find out just how serious a disease measles is we may hope for better conditions. Until that time the children whose hearing is impaired, whose eyesight is ruined or weakened, who have tuberculosis and "weak lungs," following measles will continue to grow up among us and help to swell the crowded ranks of the defectives, the "weak sisters" of life.

Turn to De Schweinitz and Randall's American Text, Book of Diseases of the Eye, Ear, Nose and Throat and glance through its pages in search of measles and its effects. You will find it stated that stricture of the nasal duct may follow measles, due to inflammation of the nasal mucous membrane. Again you will see that optic neuritis is observed in the great variety of infectious diseases, and is commonly noticed in the course of measles. In treating of inflammation of the middle ear, these authors state: "The acute affections of the middle ear come most frequently by extension from the naso-pharynx. Consequently, the exanthemata, and especially scarlet fever, are among the most frequent causes of a systemic nature. A large percentage of the inmates of the institutions for the deaf date their infirmity from an attack of scarlet fever in childhood. In measles the ear is still more frequently affected. It has recently been shown that the ears are probably involved in every case of measles. An exudation containing the specific organism of measles is formed on the lining mucous membrane of the tympanum by the eruption. But unless this be mixed with one of the pyogenic germs, this exudation is rapidly absorbed without perforation of the drumhead and without injury to the hearing."

In another place in giving the etiology of middle ear trouble as related to various diseases they give us these significant figures: "Solmonson found deaf-mutism caused by measles in 5.6 per cent; Hartman, 3.6 per cent. Tobeitz found otitis media in 21.9 per cent in convalescent children. Of 22 children dying from measles, the ears of 17 were examined post-mortem, and in every one the mucous membrane of the middle ear was found to be diseased, although in only 7 of them had there been any clinical manifestation of ear-complication."

Looking at the subject in this manner—in retrospect as it were—we begin to realize that here we have a disease worthy of serious thought. When we look at the simple case of measles it looks so truly simple that we are apt to forget these sequellae.

An epidemic of measles in our army occurring at Columbus, Barracks, Ohio, last year in which 183 cases developed, showed

a death rate of 8.2%. The following complications occurred during this epidemic: broncho-pneumonia, 23; pleurisy with effusion, 11; otitis media, 13; mastoiditis, 3; meningitis, 1; pericarditis with effusion, 3; abscess of lungs, 2. At autopsy in one case a large tuberculous abscess was found in the apex of each lung, and two had healed tuberculous nodules. The deaths in this epidemic were practically all from some lung involvement, one, however, being from meningitis following involvement of the mastoid.

Broncho-pneumonia is the most frequent complication of measles. Other complications are catarrhal or membranous laryngitis, occasional edema of the glottis, ophthalmia, involvement of cervical glands, otitis, cancrum oris and diarrhea. The health of the child is many times impaired after an attack of measles, and it is during this period that we find whooping cough, diphtheria and nephritis. Later, an acute tuberculosis may arise, as measles leaves a soil very favorable to the growth of the tubercle bacillus.

Our own State Board of Health is doing a lot to teach the people the seriousness of measles, and in its Kansas Health Almanac for 1912 measles occupies a prominent place. In the bulletin issued by this department we find these statements: "It (measles) causes in the United States nearly three times as many deaths as smallpox, and nearly as many as scarlet fever.

Measles and whooping cough together cause nearly as many deaths as diphtheria. The records of the State Board of Health show that for the past four years the death-rate from measles has been six times greater than from smallpox, and the returns for the month of April, 1910, also show that the actual number of deaths from measles in the state during that month was more than that from diphtheria, scarlet fever and small-pox combined. The failure to promptly recognize the beginning of pneumonia in many cases of measles may result in the death of the patient, who could have been saved had proper precautions been taken."

This bulletin also graphically brings out the fact that measles is vastly more fatal in children under five years of age. Could we get the parents to realize this important fact there would be just that one more incentive for care in keeping the children from being exposed to measles needlessly.

Before the State Board of Health required us to quarantine measles there was some slight excuse for our lack of care, but now, since the State Board has ruled that all cases of measles must be

effectively isolated and quarantined, we have no excuse whatever for failing to give our measles patients the care they require and the rest of the community the protection that is due it.

As for the treatment of measles we will say but little. Good nursing is of greatest importance and drugs little needed, except for complications. We should always be on our guard and any lung involvement given prompt attention. Frequent examinations with ear speculum is the only way to detect ear complications in their incipiency. Baginsky states that local disinfection seldom does much good in measles otitis until after perforation, when suitable measures usually lead to rapid cure. He says that in case of high fever of symptoms of meningitis accompany the otitis, the membrane should be incised without delay. Diphtheria some times accompanies measles and this combination is very dangerous for we are apt to overlook the diphtheria. If we find the diphtheria bacilli, antitoxin should, of course, be used.

Every patient with measles should be quarantined, the other children of the family kept away from public gatherings, the parents instructed as to the proper care and the public taught that it is a disease of gravity and not a simple "breaking out."

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ERRORS OF REFRACTION CAUSING NEURASTHENIA AND EPILEPSY.

CLIFFORD P. JOHNSON, A. B., M. D., Coffeyville, Kansas.

Late Instructor in Physiology, University of Kansas.

Read before the Montgomery County Medical Society, Feb. 16, 1912.

The retina of each eye receives a picture which is carried by the nerve to the percipient centers. These pictures, although not identical, are mentally combined and recognized as representing one subject.

This result is accomplished only, when the percipient centers have come to recognize the fact that the vision of an object falling upon the macula of each eye must be mentally interpreted as one object, and not as two. In the course of time this knowledge becomes so automatic that if for any reason the picture of the object looked at falls in one eye elsewhere than on the macula, two images are immediately perceived and confusion results. In order that this parallelism of the visual axes of the eyes shall be maintained with as little muscular and nervous fatigue as possible it is necessary that it should always be present without active, conscious or unconscious effort. The importance of the

fact has long been recognized, and a weakness of the converging muscles has been for many years considered a defect which produced eye strain. The probability that such a defect or that other inequalities of ocular balance might be a source of nervous irritation sufficient to precipitate or produce grave functional nervous disturbances other than asthenopia and headache was first brought before the profession by Dr. George T. Stevens of Belgium in 1883.

Clearness of vision requires that the rays of light which form the image on the retina shall be accurately focused, and this result necessitates that there shall be exercised a suitable amount of accomodation for every given amount of convergence upon looking from a distant to a near object. An error of refraction may blurr the picture for a near as well as for a distant object, but when it is possible to do so the eye brings to its aid the cilliary muscles, and by this means corrects the error of focus and secures a sharp definition. Now, it is an established fact in ophthalmology that headache, mental, physical and nervous fatigue amounting even to confusion and inability to think, may be dependent upon this correction of an error of refraction by the cilliary muscle. These symptoms must be due either to fatigue of the muscular apparatus, or to the nervous fatigue of the central nervous system developed by a constant semi-conscious or unconscious effort to hold the cilliary muscles up to their duty, or it may be, to mental fatigue of the percipient centers due to the difficulty of recognizing a partially blurred image; yet, it is to be remembered that for every effort of accomodation there is associated convergence, associated either from actual correlation of the brain cells or from habit.

The third cranial nerve supplies not only the cilliary muscles, and the sphincter of the iris, but, also the internal rectus, superior rectus, inferior rectus, and inferior oblique, from which anatomical arrangement it is evident that accomodation and convergence are necessarily associated and of equal importance for comfortable binocular single vision.

NEURASTHENIA.

Such cases complain of pain in the occipital region, often of a pain in the back of the neck, not infrequently a pain in the spine, down as far as between the scapulae; often a giddiness, which is never so pronounced that the patient falls, and is most frequently present upon first arising in the morning, in crowded streets, or when looking at rapid moving objects. They are very apt to complain of a sense of confusion in thronged thoroughfares; of being car sick on railroad journeys; of being unable to watch

passing scenery from a railroad train without fatigue, headache and, perhaps, confusion that they are unable to study, or to concentrate their thoughts upon subject matter of the text, or to think logically in connection with what they read; and they do not like to meet and talk to people or to look steadily at any object. These symptoms, when the occupation of the individual is so as to call them forth, slowly increase in intensity, and gradually the headaches are not confined to the occipital region, but become more and more a marked feature of the clinical picture, until, finely, the patient is reduced to a condition of neurasthenia, which compels him to abandon his occupation, retire to some quiet locality, and spend months in allowing his mental nervous equilibrium to re-establish itself. Then only too often upon returning to his usual work the same story repeats itself again and again, until the patient becomes a nervous, querulous, irritable invalid, utterly unfitted for any occupation which requires either the use of the eyes or mental application.

EPILEPSY.

Epilepsy is one of those distressing conditions, whose etiology is generally attributed to heredity. "Direct inheritance is comparatively uncommon, yet the children of neurotic families in which neuralgia, insanity, and hysteria prevail are more liable to fall victims to the disease." The most potent predisposing factor in the production of epilepsy is chronic alcoholism in the parents. Syphilis and alcohol are also direct causes of the disease. Certain local conditions cause epilepsy by reflex action. Besides an error of refraction as a reflex cause of epilepsy; dentition, worms, the irritation of a cicatrix, or some local affection, such as adherent prepuce, or a foreign body in the ear or the nose, have been known to cause the disease.

The history of the following case is an example of a reflex cause of epilepsy due to an error of refraction. Mary N., thirteen years of age, had the following family history; an aunt on her mother's side had chorea. The father's mother was insane. A sister had an error of refraction, but did not wear glasses. The patient had always been well up to her eighth year, when she had epileptic convulsions preceded by a cry, after which she became rigid and had general convulsive movements. She would remain unconscious for some moments, and after recovery from attack was sleepy. She was much more subject to these attacks when she attended school, and they had continued with more or less frequency for five years. She had one slight convulsion on the night following the first day of wearing glasses, after which there were no

more epileptic convulsions. If, then, this distressing neurotic condition can be prevented by the correction of an error of refraction or the removal of some local cause in a few cases, the time and effort put forth to find the genuine cause of reflex epilepsy, will have been well spent.

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SCARLET FEVER—A FEW OBSERVATIONS.

DR. W. L. WELSH, Hazelton, Kansas.

Read before the Barber County Medical Society, Jan. 24, 1912.

Having had a very limited experience with this particular disease; its etiology, symptomatology, treatment and complications being so well known to the profession, I feel it worse than useless for me to attempt anything along that line.

Skeptics are usually of the class called bores, but in the face of this, I shall acknowledge that study and observations has made of me a confirmed skeptic regarding some of the things taught in medicine, especially in the one very important branch, that of bacteriology, and it is of a few observations along this line that I wish to speak briefly.

Thousands of men in every civilized country are occupied in expounding old ideas which are known to be and have been proven erroneous, Many gain fame as well as pecuniary benefits from teaching theories long since exploded. The Darwinian theory of evolution, in which the medical fraternity to a great extent believe, is quite complete up to certain point. The classification and development of bacteria is quite well established, but the origin of the species is not known and no plausible theory is advanced for this very important point in arriving at the definite cause of diseases and the origin of germs, as well as the beginning of the various epidemics. The division line between the animal and the vegetable cell is so indistinct that many verbal wars are waged as to what classification certain cellular bodies belong. This may indicate the way to the missing link and when settled, complete the evolutionary chain.

It may or may not have occurred to many of you that most germs might have a common origin, and that what now are called "species" might come to be known as one of the many stages of development of certain protoplasmic bodies that even now are known to have a cycle of development, and that it is during this cycle of development that many of the germs and bacteria of the

old classification are demonstrable as well as some that are not in the classification.

It is here that I wish to call attention to an observation made during an epidemic of scarlatina, that brings out the point that I desire to make. In the family were some seven or eight children. Two had scarlatina of a moderately severe type; three had it rather light and the others showed no signs of the disease except perhaps a little sore throat. Immediately following this, two of the children that did not have scarlatina, developed typical cases of typhoid fever, and one that had scarlatina moderately severe, together with the mother who had had some sore throat, had inflammatory rheumatism. In trying to study out the connection that the scarlatina had with these diseases following, and having made former microscopic studies with a co-laborer, Dr. H. G. Graham, and having observed the cyclical development of germs from the protozoan, I concluded that in this instance the patients who had had scarlatina of the more severe type had developed in their tissues sufficient antibodies to prevent further development of the organisms, but the ones who had shown no signs of the disease, had in reality had the infection and not sufficient antitoxins generated to retard further development of the organisms and this process had continued to a period when the body was flooded with the typhoid germs and their toxins and the patient succumbed to this particular disease; and likewise, the ones who had had it lightly, in them only sufficient immunity was given to delay rapid development, but even in these the organisms had reached a period in the cycle of development when they came down with rheumatic infection.

This observation led to microscopic study of a certain protoplasmic mass found in most drinking waters and commonly called the amoeba, which is a protozoan and which microscopically resembles the leucocyte of the blood. This study which was carried on over a period of time, proved that this organism had stages of development varying under conditions, and that during this time most of the known pathogenic germs were demonstrable and that during this time the original organism was lost sight of, but that in time they again showed up in countless numbers, and the one conclusion could be drawn, namely, that the cycle of development had been completed and the interval was occupied in making a new bacteriological theory. That this organism, owing to environment and developmental changes, had been in many instances mistaken for a phagocyte, and that instead of the leucocyte flocking to the point of injury as a phagocyte, a scavenger, a life

saver, that it might be this organism coming here simply because the conditions were suitable for its growth and rapid development, and that in many instances the infection came from these bodies and not from an external source. I realize the fact that this is contrary to all teaching and that I may be branded a medical heretic, and given no mention in our great medical journals, but are you satisfied with the bacteriological data given on pneumonia, influenza and many other diseases as well, as the lack of explanation as to how the various epidemics get started? Nothing results without cause. Everything scientific has a plausible explanation and is demonstrable, but there are many things in etiology of diseases that are not even explained, let alone demonstrated. May not Metchnikoff's phagocytic theory be erroneous as well as some of the other noted theories? I predict the day to soon come when it will be fully shown that in many of the essential points it is entirely wrong and we shall have a new and more scientific explanation for many diseases and conditions.

Why do some diseases occur almost never in the warm months while others practically never occur during the cold months? Why are some diseases found only in certain localities and never in others? How is the sudden onset of certain diseases explained? Why are some diseased conditions found in every corner of the world? Cancer and tuberculosis that have been microscopically demonstrated to be, almost beyond doubt, the same organism in a different stage of development, are found practically everywhere and under all different conditions and surroundings, affecting alike the rich and the poor. All people use drinking water and few if any of the waters used for drinking, unless made sterile, are free from protozoa, and through this medium these organisms gain access. A cancer body, the leucocyte and the protozoan resemble each other under the microscope. A cancer body shows acid fast properties under the stain, and if a protozoan is put under suitable conditions, in a very short time acid fast bodies are demonstrable and often typical tubercle bacilli can be shown.

May not the sudden onset of pneumonia be explained by the fact that these protozoa in the body have reached a certain stage in development when the whole circulatory system becomes flooded with the diplococcus of pneumonia in a very short space of time? This organism has been shown to develop in this manner from the protozoan and to flood the field at a certain stage with the typical diplococcus of this disease.

These points have been demonstrated to my satisfaction more than once, and while they may not be listened to now, yet they are

so simple that they are plausible and undoubtedly clear up some of the heretofore unexplained points.

Time forbids my entering into this subject in detail, and I wished in this short paper to give only the thought as it had come to me from observations following in the course of study of scarlatina and its varied sequella and complications.

In conclusion, I am led to wonder how long the Metchnikoff theory of phagocytosis will be held together and how soon it will be laid away with the many other exploded theories. If this wonderful, life-saving, petted and haloed scavenger, might not be a devil in disguise, a destroyer with whom we had not yet reckoned, with whom we are about to become acquainted. That instead of its hastening to a point of injury or infection as a scavenger or life saver, if it might not have stationed itself here from the fact that here it found suitable surroundings and conditions for its rapid development, and instead of its fighting for the body it might be aiding the invading enemy.

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THE DIETETIC TREATMENT OF CHRONIC INTERSTITIAL NEPHRITIS.

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PHILIP B. MATZ, M. D., Assistant Surgeon, National Military Home, Kansas.

Read before the Northeast Kansas Medical Society, Feb. 8, 1912.

The condition of chronic interstitial nephritis is one of the most prevalent of diseases, especially is it common in the aged. The 1910 report of the National Home for Disabled Volunteer Soldiers shows that out of a total of 12,798 patients treated in the hospital departments, 997 were diagnosed as chronic interstitial nephritis and of this number 184 died. It is interesting to note that 310 of the 997 cases were being treated at the National Soldiers' Home, Togus, Me. The reason for this is to be found in what Purdy says, namely, "that the cold moist climate of the New England and Middle States predisposes to contracted kidneys."

There are a great many conditions which may cause it, but I think that the principal etiological factor in the aged is to be found in an altered and deranged gastro-intestinal function, and faulty metabolism, due to indiscretion in diet. Repeated gastro-intestinal disturbances may be followed by the production of unnatural chemical products, and these may be irritating on the kidneys and bring about the condition under discussion.

Faults on the part of such organs as the liver, pancreas, adrenals, thyroid gland, or even the muscles, might, by malperformance of function, lead to chronic renal disease; one very often sees cases of diabetes mellitus complicated by chronic interstitial nephritis.

Voit says, that a man at work eight to ten hours a day should ingest 118 grams of protein in twenty-four hours; Rubner advises 127 grams, and Atwater 125 grams. These figures have provoked a great deal of discussion.

Chittenden and Mendel say, that the average individual partakes of too much protein, and that a needless strain is imposed upon the liver, kidneys and other organs concerned in the transformation and elimination of the end products of protein metabolism. They teach that the daily ingestion of fifty grams of protein and food having a value of 2,500 calories, is sufficient to keep an average individual in good health. More than that throws extra eliminative work on the kidneys. The end products of portein metabolism, such as urea, creatin, hippuric acid, and phosphates are very irritating on the excretory organs and gradually set up inflammatory conditions.

In the aged, chronic constipation is quite common; this means that a variable quantity of protein suffers decomposition; a mild toxaemia is therefore always present, with resulting deleterious effect on the kidneys.

So that, as a result of deranged functions of the organs concerned in metabolism, and the ingestion of too much food, toxic substances are formed and go into the blood stream; the kidney parenchyma depends upon the blood for nourishment, the latter instead of bringing nourishment brings substances which irritate and gradually cause inflammatory changes. The parenchyma being diseased, is now unable to take care of and eliminate the end products of protein metabolism. These substances are absorbed and cause the train of symptoms present in the disease under discussion.

The condition of chronic interstitial nephritis may be combated in two ways; first, by prophylactic measures, and secondly, symptomatically, by drugs and dieting.

It has been said that the ingestion of too much food, especially protein, is one of the principal etiological factors of the condition under discussion. Every means should be adopted to spare labor to the already diseased kidneys and to the healthy kidneys in time of stress as occurs in the course of fevers and in chronic diseases. The kidneys may be so near the point of breaking down,

that injudicious dieting may supply the necessary additional irritation to cause the break-down.

It seems to me that the diet in the aged should receive more attention than is paid it at present. The gastro-intestinal tract and the glandular organs concerned in metabolic function are physiologically, abnormal; digestion is below par; furthermore, the appetite in the aged quite often is abnormal; there is an ingestion of too much food with subsequent ill effect upon the organs of digestion and elimination. The food in the aged should be nourishing, easy of digestion, and should contain a minimum amount of protein.

The drug treatment of chronic interstitial nephritis consists in combating the symptoms as they arise and is transient and very unsatisfactory; in fact it is at times very harmful inasmuch as some of the conditions that arise in the course of the disease are compensatory in character and ought not to be disturbed.

Polyuria, which is one of the principal symptoms is nature's effort to get rid of the excess of fluid ingested; check the polyuria, and you will most likely cause an oedema. Another example of illogical symptomatic treatment of this disease is the attempt made to reduce the blood pressure whether it be high or low. Here we have a diseased kidney which is in a condition of fibrosis. It takes rather high pressure to force blood through such an organ. The high blood pressure ought not to receive any attention unless it be so great as to cause dangerous symptoms.

To my mind the most rational form of treatment of chronic interstitial nephritis is one directed at the cause of the condition, and we know it to be a fact that one of the principal causes is a dietetic one. Reduction of food ingestion and especially of protein intake should be the aim. Of course, this form of treatment is prophylactic and palliative rather than curative. The symptoms present can be eradicated and life prolonged for some time.

The results obtained at the National Military Home Hospital under this form of treatment have been most satisfactory; grave symptoms have cleared up after the patients were placed on a low protein diet, and the functional activity of the kidneys showed marked improvement as was evidenced by the results of quantitative estimations of total nitrogen and total quantity of urine voided.

I have in mind a case admitted to the hospital on September 11, 1911, patient was a miner, 64 years of age, came in with symptoms of dyspnoea, and marked oedema of feet and legs. The heart sounds were weak and rapid; blood pressure 200; weight

150.5 pounds. The urine examination showed the presence of albumin, hyaline and granular casts. Total quantity voided in 24 hours, 375 cc. Total urea 5.60 grams.

He was put on well regulated diets consisting of protein which ranged from 62 to 68.5 grams in 24 hours, and worth from 1975 to 2190 calories. The water ingestion was restricted to 3 tumblers in 24 hours. On September 18, 1911, the patient weighed 147 pounds, having lost 3.5 pounds in a week's time, he voided 1850 cc. of urine, total urea excreted was 16.65 grams, and there was a marked reduction in the oedema. On September 25th patient weighed 145.5 pounds, and on October 16, 1911, he weighed 142 pounds, having lost 8.5 pounds in a month's time. The grave uraemic symptoms disappeared and the dropsical condition was no longer present, the dyspnoea also left him.

How was this accomplished? Merely by allowing the kidneys to rest and recuperate. The food and fluid ingestion was lessened materially so that the functional activity of the kidneys was reduced to a minimum.

In treating a case of chronic interstitial nephritis enough food must be given to meet the demands of the body. The diet must not be harmful but palatable; and the patient should be able to tolerate it for months or years if necessary. Simple easily digested food should be the rule, and taken with regularity. Rich and highly seasoned foods should be avoided. Condiments are not to be used, sweets and desserts are to be eaten sparingly.

The diet must contain a moderate amount of protein, as the latter is very essential. Absence of it should cause gradual loss of weight and cachexia.. A certain proportion of water and inorganic salts are also necessary for the maintenance of life.

Milk—As was mentioned before the diet, in chronic interstitial nephritis must be moderate in amount, palatable, and tolerated for a long time if necessary, so that milk alone as the diet, is out of the question, inasmuch as large quantities would have to be ingested daily in order to obtain sufficient amount of protein and a necessary number of calories. This would throw extra work on the heart and the kidneys, besides the monotony of the diet would tend to loss of appetite and gastro-intestinal disturbance. A moderate amount during the day, however, is most desirable. A tumbler of milk contains 8 grams of protein and has a fuel value of 140 calories.

Meat—Some clinicians are opposed to a meat diet in chronic interstitial nephritis, while others advocate a moderate use of same, say once a day. There is no more harm in a moderate meat

ingestion than there is in the use of other foods provided the total intake per day is not too great. Lamb chops are excellent in the diet of the nephritic. The lean portion of the chop contains 8 grams of protein and is worth between 50 and 100 calories.

Alcohol—If possible a patient having a chronic kidney lesion should avoid the use of alcoholic drinks. Where the patient is old and feeble, however, with a dormant appetite, and where he has been in the habit of taking alcohol all his life, the moderate use of wine and whiskey should be allowed and even encouraged. Each gram of alcohol is worth seven calories so that the fuel value of the beverage given can be easily estimated if the alcoholic percentage and the quantity are known.

Tea and Coffee—These beverages have no fuel value and may be given to nephritics in moderate amounts.

Condiments—These substances like pepper, mustard, garlic and nutmeg have no fuel value as a food, and are not metabolized. They are eliminated by the kidneys and irritate these organs; they should therefore not be used in chronic interstitial nephritis.

Carbohydrates and Fats—In order to make up the caloric value necessary for an adult considerable carbohydrate and fat must be taken in addition to the protein. Butter, cream and oil may be ingested; they impose no work whatever on the kidneys and add fuel value to the diet. Cereals, bread, vegetables and fruit may be eaten; their protein constituent is low, but fuel value rather high. The fodder vegetables, like asparagus, string beans, cabbage, cauliflower, celery, lettuce and tomatoes, do not furnish any protein and have practically no fuel value; they may be ingested ad libitum.

The question of fluid indigestion in a case of chronic intestial nephritis is very important. How much water shall the patient be allowed? There are two views; H. Strauss advocates the giving of water freely, even in excessive amounts with the object of flushing out the tubules of the kidney. The other view, championed by Von Noorden limits the quantity of fluid, contending that one of the functions of the kidney is the elimination of water, and to ask a damaged kidney to increase its functional activity is to violate the principle of rest for a diseased organ. The latter view is upheld by the profession and is the more sound of the two.

Fluid ingestion may be best regulated by finding out the total quantity of urine the patient voids from day to day and allowing him to take about the same amount of liquid. Ingestion

of too much increases the oedema and dysponea and is very injurious to the already overworked kidney.

The question of salt ingestion in chronic interstitial nephritis has aroused a great deal of discussion and contention. There is a prevalent idea which is supported by clinical investigations and results that a salt free diet tends to decrease the oedema, while a diet including an excessive amount of sodium chloride, increases the oedema. The investigators who make this claim say that their results were obtained in some cases with failure in others.

Some observers claim that the diseased kidneys are unable to eliminate sodium chloride, and that an abnormal quantity of the latter accumulates in the tissues, the serum being retained there to keep it in solution thus keeping the dropsy. Others say that the retention of water and the dropsy are primary, and the sodium chloride is required to balance the osmotic pressure in the blood, hence its retention.

Sodium chloride is very necessary in the economy of the body and to give a patient a diet which is free from this salt is, I think, bad policy. It is a known fact that hydrochloric acid is formed from sodium chloride ingested. Stop the taking of salt for a long period and there will be a diminution of hydrochloric acid secretion, with subsequent impairment of gastric digestion and gradual anemia and cachexia.

Forster fed dogs and pigeons a diet in which sodium chloride was reduced, the animals soon died. It seems as if they died more quickly while on a diet poor in salt than if they had been entirely deprived of food. So that I do not think it good treatment to stop the ingestion of sodium chloride altogether. A reduction in the quantity usually taken would be the better plan.

The mode of treatment used at the National Military Home Hospital is as follows: the diagnosis of chronic interstitial nephritis having been made, the patient is weighed, and a twenty-four hour specimen of his urine is obtained and examined for total urea or total nitrogen, and for total quantity. His blood pressure is also ascertained. The amount of liquid the patient is allowed is regulated by the quantity of urine voided in twenty-four hours. He is placed on the following diets:

DIET NO. 1.

BREAKFAST.

	G Protein	Calories.
1 Pat butter	0	80
1 Egg	8	100
1 Cup coffee	0	0
4 Ounces cream	4	240
2 Teaspoonfuls sugar	0	50
2 Slices bread	8	230
8 Teaspoonfuls corn flakes	4	160
DINNER.		
3 Ounces beef	16	100
2 Slices bread	8	230
1 Pat butter	0	80
½ Pint soup	8	130
1 Glass milk	8	140
SUPPER.		
2 ⅔ Tablespoonfuls scrambled eggs	16	180
1 Cup coffee	0	0
2 Tablespoonfuls sugar	0	50
1 Ounce cream	1	60
1 Slice bread	4	115
1 Pat butter	0	80
Total	85 G.	20.25 Cal.

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DIET NO. 2.

BREAKFAST.

	G Protein	Calories
1 Large orange	0	100
1 Shredded wheat biscuit	4	100
2 Ounces cream 20%	2	120
1 Slice bacon ½ ounce	1.5	90
1 Potato (medium)	2	90
1 Cup coffee	0	0
2 Teaspoonfuls sugar	0	50
1 Pat butter	0	80
1 Slice bread	4	115
DINNER.		
1 Glass milk	8	140
½ Pint soup	8	130
4 Tablespoonfuls boiled rice	4	200
1 Slice bread	4	115
1 Pat butter	0	80
3 ⅓ Ounces bread or rice pudding	4	175
SUPPER.		
1 Slice bread	4	115
2 Eggs	16	200
1 Ounce cheese	8	120
1 Cup coffee	0	0
1 Teaspoonful sugar	0	25
1 Ounce cream	1	60
Total	70.5 G.	2105 Cal.

DIET NO. 3.

BREAKFAST.

	G Protein	Calories
1 Large orange	0	100
4 Tablespoonfuls cooked cereal	4	120
2 Ounces cream	2	120
2 Teaspoonfuls sugar	0	50
1 Egg	8	100
1 Pat butter	0	80
1 Cup coffee	0	0
1 Slice bread	4	115
DINNER.		
2 Slices bread	8	230
3 Slices bacon 1½ ounces	4.5	270
1 Potato (medium)	2	90
1 Pat butter	0	80
1 Glass milk	8	140
SUPPER.		
1 Slice bread	4	115
1 Large orange	0	100
1 Small cup custard	8	160
1 Pat butter	0	80
1 Glass milk	8	140
1 Egg	8	100
Total	68.5G.	2190 Cal.

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DIET NO. 4.

BREAKFAST.

	G Protein	Calories.
1 Egg	8	100
1 Cup coffee	0	0
2 Ounces cream	2	120
2 Teaspoonfuls sugar	0	50
1 Slice bread	4	115
1 Large orange	0	100
4 Tablespoonfuls cooked cereal	4	120
1 Pat butter	0	80
DINNER.		
2 Slices bread	8	230
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Tablespoonful sugar	0	25
2 Chops, or 3 ounces beef	16	100
1 Small cup custard	8	160
1 Pat butter	0	80
SUPPER.		
1 Slice bread	4	115
1 Large orange	0	100
4 Tablespoonfuls boiled rice	4	200
1 Pat butter	0	80
1 Glass milk	8	140
Total	67 G.	1975 Cal.

DIET NO. 5.

BREAKFAST.

	G. Protein	Calories.
1 Egg	8	100
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Teaspoonful sugar	0	25
1 Pat butter	0	80
1 Slice bread	4	115
1 Large orange	0	100
DINNER.		
1 Glass milk	8	140
½ Pint soup	8	130
1 Small cup custard	8	160
2 Slices bread	8	230
1 Pat butter	0	80
2 Boiled potatoes	4	360
SUPPER.		
1 Egg	8	100
1 Cup coffee	0	0
1 Ounce cream	1	60
1 Teaspoonful sugar	0	25
1 Pat butter	0	80
1 Slice bread	4	115
1 Large Orange	0	100
Total	62 G.	2060 Cal.

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RESULTS.

The results obtained with low protein diets are very satisfactory. It seems as if the good effect is not only on the gastro-intestinal tract and on the kidneys, but also on the circulatory system. Patients have been admitted to the wards with dyspnoea, nausea, anorexia, and high blood pressure, and after a few weeks of treatment with well regulated diets have improved markedly. An increased elimination of urea and total nitrogen was always noted. Those nephritics with oedema, either occult, or manifest, as a complication improved rapidly as was evidenced by disappearance of eodema and loss of weight.

Weights of patients before being placed on low protein diets, and after having been on same, showing loss of weight following disappearance of oedema;

	Before being placed on diet.		After having been on diet.		
Name	**Date**	**Weight, lbs.**	**Date**	**Weight, lbs.**	**Loss, lbs.**
Curtis	Sept. 4, 1911	116	March 17, 1912	114	2
Thomas,	Sept. 4, 1911	150	Sept. 18, 1911	146	4
Kittle,	Sept. 11, 1911	123	March 10, 1912	120	3
Turner,	Sept. 12, 1911	150.5	March 17, 1912	119	31.5
Chase,	Oct. 23, 1911	164	Dec. 4, 1911	149	15

McClure,	Oct. 16, 1911	171.5	March	17, 1912	140	31.5
Lewis,	Dec. 1, 1911	205.5	Dec.	31, 1911	195	10.5
Barnes,	Jan. 20, 1912	149.5	March	17, 1912	132.5	17
Hantz,	Dec. 1, 1911	149	Jan.	14, 1912	121.25	27.75
Schultz,	Feb. 28, 1912	150	March	17, 1912	144	6.
Purdy,	Feb. 28, 1912	196	March	17, 1912	162	34
Delaney,	Jan. 6, 1912	154.5	Jan.	14, 1912	151.5	3
Purdy,	Feb. 28, 1912	196	March	17, 1912	162	34
Delaney,	Jan. 6, 1912	154.5	Jan	14, 1912	151.5	3

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Acute Indigestion.—A valuable formula for acute indigestion in children not over ten years of age:

℞ Bismuth subnit..... ℥ij.
Cerii oxalatis.....gr. xl.
Elix. pepsini..... ℥iv.
Mist. cretae..... ℥j.
Aquae cinnimomi.....q. s. ad ℥iij.
M. Sig.—Teaspoonful every three hours.—Medical Summary.

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When dealing with a sliding hernia don't attempt to separate the large bowel from the sac; this attachment carries the blood supply of the gut. Free the sac, not the intestine, and reduce with the bowel as much of the sac as is attached to it.—American Journal Surgery.

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Active hemorrhage from a gastric ulcer is rarely fatal; the weight of evidence indicates that it is better to operate after than during the bleeding. Active hemorrhage from a duodenal ulcer is often fatal; operate as soon as the diagnosis is made.—American Journal Surgery.

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The measles and scarlatina rashes in small-pox are usually prodromal and go away before the true eruption occurs, but measles and the true eruption are very similar to smallpox at exactly the proper stage, especially in selected cases.

Points to be remembered are that the temperature remains in measles while in smallpox it generally drops when the eruption appears. The catarrhal symptoms are absent or at least very mild in smallpox as are the typical Koplic's Spots.—Ward (South California Prac.)

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Genito-urinary surgeons are agreed that in bilateral renal tuberculosis the logical treatment is removal of the diseased organ with as much of the ureter as is possible.

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EDITORIAL

It has been reported that "Professor Samuels" of Wichita, who has been treating cancer, consumption and many other chronic ailments by instilling "drops" (which the A. M. A., Journal says is composed of sugar and salt water) into the eye,is to leave the state and locate in Detroit, Michigan. We presume the "going" became a little too "heavy" in Kansas and that he at least, thinks there will be less antagonism in Michigan.

It is with copious tears (of joy) that we bid a fond farewell to the "Professor."

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After twenty-nine years of active service as chief of the Bureau of Chemistry in the Department of Agriculture, Dr. Harvey W. Wiley has resigned. He gave as his reasons the belief that he could be of more service in the pure food and drug law enforcement as a private citizen, than in an official capacity. The reason for this can be readily explained from the fact that he has been hampered in his work by his associates and his superior officer the head of the Department of Agriculture. It is too bad that Dr. Wiley has been forced to this action, and his resignation will be received with profound regret by every honest man, who is acquainted with any of the work done in Dr. Wiley's department.

An editorial in the Journal A. M. A., March 23, makes some statements which are well to the point and worth reprinting:

DR. WILEY RESIGNS.

Damned with faint praise from the nation's chief executive, hampered by a reactionary departmental chief who has long since outlived his usefulness, badgered by a pettifogging lawyer of the night-school variety who, as a representative of the vicious interests, was able to nullify or render abortive efforts made in the interest of public health, Dr. Wiley has given up the unequal fight and handed in his resignation. Thus retires from the government service one of the most useful officials this country has ever had. An implacable foe of fraud and deceit, Dr. Wiley has for years stood between a more or less helpless public and the vested interests that have developed to a science the business of adulterating foods and sophisticating drugs and in other ways threatened the public health. On every debatable question regarding the wholesomeness of food stuffs, Dr. Wileywas consistently on the side of the people; his superior officers have been just as persistently on the side of those who have made their millions by substituting cheap and often poisonous drugs for more expensive but wholesome foods. Assailed from without by some of the most powerful, vicious and corrupt of organizations, he was also antagonized from within by the political henchmen of the same organizations. To Dr. Wiley more than to any other one man, the public owes the Food and Drugs Act and to Dr. Wiley it also owes whatever of good has been accomplished by that act. It is to be hoped that his forced retirement will result in such an upheaval of public indignation that the forces of evil at present in control of the Department of Agriculture will be driven into political oblivion and the department filled by men who hold decency above dollars, probity above pelf and public health above private gain.

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The Branaman Remedy Company, who have waxed fat on the credulous Kansans' and numerous others with loss of hearing, have (Journal A. M. A., March 23, 1912), 'received a set-back from the United State Circuit Court which will in all probability put them out of business for some time to come. The following comment from the Journal A. M. A., is interesting:

THE BRANAMAN REMEDY COMPANY.

Fraud Order Sustained.

The Dr. Branaman Remedy Company, a mail-order medical fake of Kansas City, exploiting a "cure for deafness," against which a fraud order was issued by the Post-Office Department, has received a final knockout blow through a recent decision of the United States circuit court for the western district of Missouri. The company had applied for a preliminary injunction against the postmaster of Kansas City to restrain the enforcement of the fraud order. This was denied by the court. In The Journal, Nov. 26, 1910, p. 1908, the story of this concern, which is conducted by Dr. G. M. Branaman, its method of exploiting the public with a cure for deafness and the results of an investigation by the Post-Office Department, was given at some length. It was the old and familiar falsehood of the great specialist who promised his victims free treatment and special personal attention. The usual symptoms-blank was required to be filed out, the stereotyped letters and the ready-made diagnosis were sent the victim, but instead of receiving free treatment, he was required to remit a neat sum for the apparatus and the whole outfit for the treatment of his case. Fraudulent testimonials were furnished and the whole rigmarole of the faker and the quack was gone through with. After investigation by the post-office employees, who took the role of patients of the quack concern, the Postmaster General issued the fraud order. The court, in reviewing the case on the application for the preliminary injunction, taking into consideration

the evidence accumulated by the Post-Office Department and such defensive matter as was submitted by the Branaman Remedy Company, held that the evidence not only warranted the making of the fraud order by the Post-Office Department, but amply sustained it. Where a fraud order is issued, in the opinion of the court, the presumption is in favor of the legality of the action of the Postmaster-General, and a strong showing is necessary to warrant the granting of an injunction. The court further says that the only cases in which courts will disturb a fraud order made by the Postmaster-General are when it is tainted with fraud, absolutely without authority of law, clearly outside of the statute, or, perhaps, clearly, palpably and obviously wrong. In the application for the injunction the complainant in his bill in equity claimed that his business and that of the Branaman Company "is and always had been a lawful one." The court said, "What might otherwise be a legal business or profession may be so conducted as to render it a vehicle of fraud and deception and bring it within the purview of the statutes authorizing the Postmaster-General to refuse the use of the mails in furtherance of schemes to defraud."

An interesting feature of the complainant's bill of equity asking for the restraining order against the Kansas City Postmaster was the allegation that the action of the Postmaster-General was the result of a conspiracy involving the American Medical Association, the Jackson County (Mo.) Medical Association and a number of doctors of Kansas City, as well as the attorneys for the government and the United States post-office inspector. This seems to be becoming the favorite defense of the quack, the faker and the nostrum-vender, when they are brought to book for their fraudlent methods—claiming conspiracy with others on the part of the American Medical Association, the great "medical trust", which seeks to destroy a lot of innocent, but enterprising gentlemen who are only seeking to benefit the people and incidently to earn an honest dollar. It is gratifying to know that through this deep-laid conspiracy the Branaman Remedy Company has been put out of business for a time—at least, until Branaman turns up again with some similar scheme or with the same old fake under a new guise and name—and that the credulous public has thereby been saved probably thousands of dollars, much suffering and permanent injury.

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The Missouri state superintendent of insurance, has issued a ruling, prohibiting insurance companies from writing insurance indemnifying physicians against damages for mal-practice. (Journal of the Missouri State Medical Association.)

Where he gets his authority for such an act is beyond comprehension. If there is a law on the statute books which refuses to grant physicians the right to protect themselves from grafters and shyster lawyers., then Missouri has taken a step backward from progress. There can be no possible excuse for such a ruling or for the passage of such a law. Certainly, no one could accuse physicians of mis-treating patients or giving them insufficient care simply because they are protected from mal-practice damage suits. Nor can we see how the fact that insurance companies cannot settle a suit without the consent of the physician, should make any material difference to the state. The policy would be of little value to the holder if companies could settle damage suits for mal-practice which are mostly fakes, without the consent of the physician. This could be taken advantage of many times by insurance companies, who could settle "trumped

up" claims for much less than the attorneys fees and court costs of the case.

Again, there would spring up claim after claim without merit, filed in the hope that a settlement could be made for a few dollars.

One cannot help but wonder how legislators who are presumed to have at least ordinary intelligence, can pass laws of such a character. Perhaps under the theory that "might is right."

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The annual meeting of the Kansas Medical Society will take place in Hutchinson, May 1 and 2.

It is needless to say that your attendance is very much desired and a glance at the program will show you that if you do come you will be more than repaid for the trip. The meeting will occupy but two days, (Wednesday and Thursday), whereas, in the past it has been three, the last one being "get-away" day, there being but few members to hear the closing of the program.

With the election of officers on Thursday, and the annual banquet on Thursday night the attendance will undoubtedly be as large the second day as the first. The program is all that could be desired; many papers being of great interest to the profession at this time, for instance: Cerebro-Spinal Meningitis; Secondary Suppuration, following Appendical Abscess; Treatment of Cancer of the Cervix Uteri; The Prevention of Tuberculosis and many others. It seems that every paper on the program is of such interest that we cannot afford to miss hearing one of them. There will be nothing to interfere with the program in a social or business way.

An automobile ride has been planned for the ladies at 2 p. m., on Thursday.

The headquarters will be at the Hotel Bisonte. Registration will be at the place of meeting in the New Convention Hall, Corner Avenue A and Walnut Streets. Following is the program:

PROGRAM OF THE MEETING OF THE KANSAS MEDICAL SOCIETY.

HUTCHINSON, KANSAS, MAY 1 AND 2, 1912.

Call To Order. Dr. Clemons Klipple, President Reno County Medical Society, Hutchinson, Kansas.

Invocation. Rev. Clarence S. Sargent.

Address of Welcome. Prof. Geo. W. Winans.

Response on Behalf of the Kansas Medical Society. Dr. J. T. Axtell, President Kansas Medical Society.

Meetings will be held in the new Convention Hall, Corner Avenue A, East and Walnut Streets.

Thursday Afternoon 2 p. m., Automobile Ride and Visit for Doctor's Wives to Morton Salt Plant and Kansas State Industrial Reformity.

Banquet Thursday Evening, May 2nd, at 9. p m., Bisonte Hotel.

"The Rights of a Child", Dr. J. R. Scott, Newton.

"Treatment of Lobar Pneumonia," Dr. X. Olsen, Clay Center.

"Development of the Elbow Joint," Dr. W. C. Lathrop, Norton.

"Hydrophobia," Dr. C. F. Hoover, Saffordsville.

"Cerebro-Spinal Meningitis," Dr. J. M. Parrington, Emporia.

"Medical Education in Kansas," Dr. S. C. Emley, Kansas City.

Paper—Dr. A. J. Weaver, Concordia.

"Artificial Infant Feeding," Dr. J. T. Scott, St. John.

"Catching Cold," Dr. N. Hayes, Seneca.

"The Present Status of Our Knowledge of Exophthalmic Goitre," Dr. E. C. Bowers, Wichita

"Cholecystitis With or Without Stone," Dr. Thor Jager, Wichita.

"Renal Stone," Dr. Martin Hagan, Wichita.

"Why A Medical Society," Dr. O. P. Davis, Topeka.

"Cord Changes in Pernicious Anemia," Dr. Ralph Hertzler, Newton.

"Surgical Treatment of Hallux Valgus," Dr. Jno. L. Grove, Newton.

"The Medical Profession," Dr. C. C. Goddard, Leavenworth.

"The Leucocytes in the Aged," Drs. P. B. Matz and H. M. Beardall, Leavenworth.

Paper—Adolph Koerber, Russell,

"Secondary Suppuration, following Appendiceal Abscess," Dr. Arthur Bowles, Ellsworth.

"Some Consideration in the Diagnosis and Treatment of Diseases of the Middle Ear," Dr. E. N. Robertson, Clay Center.

"Is Cancer Contagious, With Report of Cases?" Dr. J. C. Kirby, Cedar Vale.

"Anti-Tuberculosis Fight, and Some Field Notes," Dr. J. J. Sippey, Belle Plains.

"Typhoid Fever and Its Treatment," with Report of One Case," Dr. Paul Christman, Parsons.

"Typhoid Vaccine," Dr. M. D. McGomas, Fall River.

Paper—Dr. H. W. Manning, Eureka.

Paper—Dr. G. W. Jones, Lawrence.

"Closer Supervision of Pregnancy," Dr. H. L. Chambers, Lawrence.

"Physiological and Pathological Conditions as Revealed by the Urethra Cystoscope," Dr. C. S. Evans, Hutchinson.

"The Treatment of Cancer of the Cervix Uteri," Dr. Geo. M. Gray, Kansas City, Kansas.

"Appendix, Gall-Bladder & Co., What is the Relation Between These?" Hugh Wilkinson, Kansas City.

"Some Experience as Health Officer," Dr. W. T. Grove, Eureka.

"Hemorrhoids," Dr. W. W. Yates, Topeka,.

"Asthenopia," Dr. D. E. Esterley, Topeka.

"Tabes Dorsalis," Dr. E. H. Martin, Clay Center.

"Tonsils and Adenoids," Dr. H. L. Scales, Hutchinson.

"Country Practice in the Southwest," Dr. G. E. Kendall, Englewood.

"Diagnosis and Treatment of Ringworm," Dr. Leon Matassarin, Lawrence.

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Dr. George W. Maser of Parsons, Kansas, one of the most widely known physicians of the state, died at his home March 26. The cause of his death has not been learned at this date. To all those whose good fortune it was to know Dr. Maser, he was a man of sterling integrity, forceful in character, capable as the best, and a gentleman in the very best sense of the word. He was well-known in the medical societies, he being a member and a regular attendant of the Labette County, the Southeast Kansas, the Kansas State and the American Medical Association. He was well-known among the ophthalmologists of the country, chiefly by his contributions on detached retina, he having been very successful with an operation for this condition. He was much loved by his fellow-townsmen, who speak of him in the highest terms. He leaves besides his wife, two sons; George L. and John H. and a daughter, Miss Pearl. The funeral services were held Friday March 29. To have lived the life of Dr. Maser, was to have lived the best. To have done the good to humanity that he did, was to have done the best. Withal to be a man as he was nothing could be a higher ambition. The following short history is taken from the Parsons Sun:

Dr. George W. Maser was born in West Wheeling, Ohio, just across the state line from Wheeling, W. Va., Feburary 12, 1856. He attended the St. Vincent academy until 15 years of age when he went on a farm with his father at Rock Hill, Ohio. Here he remained until 21 years of age when he commenced the study of medicine in Bellevue Medical College, New York, and graduated from that institution in February, 1881. December 20, of that year he was married to Miss Kate P. Wuth of Bellaire, Ohio, and came to Parsons, December 30, of the same year, his death rounding out 31 years of residence in this city, most of this time occupying the office which he left 24 days ago, never again to return to it.

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NOTES OF THE ANNUAL MEETING OF THE STATE SOCIETY AT HUTCHINSON.

The meeting will be a two-day session, May 1st and 2nd.

Headquarters will be at the Hotel Bisonte.

The committee on arrangements is composed of Drs. C. A. Mann, H. G. Welsh, H. J. Duvall and G. R. Gage, all of Hutchinson.

The entertainment committee has furnished a list of the hotels of Hutchinson, with the rates charged.

HOTEL.	RATES.
Bisonte Hotel, (Harvey House).	
Chalmers Hotel,	$2.00 per day and up.
Midland Hotel,	$2.00 per day and up.
Baldwin Hotel, (American Plan),	$1.50 per day and up.

There are also several smaller hotels and a number of good restaurants.

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Upon arrival in Hutchinson go at once to Convention Hall and register.

There will be no guests from out of the state on the program. Everyone will receive the same close attention and the discussions should be spirited as the articles are all of interest.

The annual banquet will be held at the Bisonte Hotel, and it is safe to say that it will be O. K. The cuisine of the Bisonte is all that one could wish.

EIGHTH ANNUAL CONFERENCE OF THE A. M. A. ON MEDICAL EDUCATION, MEDICAL LEGISLATION AND PUBLIC HEALTH.

DR. S. J. CRUMBINE.
Delegate Kansas Medical Society.

The Council on Medical Education and the Council on Health and Public Instruction held their annual conference at the Congress Hotel in Chicago, February 26-27. The writer was appointed by the President of the State Medical Society a representative for that body. Owing to a snow blockade, our train was delayed so that the first half day of the conference was missed.

Mr. Frederick G. Hallette, secretary of the Royal College of Physicians, London, addressed the conference on "The System of Examinations of the Conjoint Examining Board." The examination of medical students for the degree of M. D., is conducted in the teaching hospitals by actual work upon clinical material, thereby demonstrating their fitness in a practical manner for entering upon the practice of medicine. This includes not only the physical examination of the patient and carefully prepared history, but such laboratory work as the case in hand, would necessarily require for a proper and scientific diagnosis. The same principle is applied to all the various departments of the teaching hospital, so that the entire list of subjects upon which examinations are held are of an intensely practical nature, very little stress being placed upon the written examination.

Things not included in practical work are taken up in an oral way, and thus each student is required to demonstrate his ability and to make manifest his merit before the degree is conferred.

Probably the paper that aroused the most interesting discussion was the one read by Dr. Reuben Peterson, Professor of Obstetrics of the University of Michigan, on "The Relation of the Medical School to the Interne or Hospital Year." The orator recommended the adoption of the fifth or hospital year, as a requisite for completing medical education. It was recognized that if the medical schools of the country adopted this program, which was universally endorsed by all of those taking part in the discussion, that it would neccessitate co-operation on behalf of all the larger hospitals of the country, in order that all the graduated students be furnished the opportunity to take the hospital year. Logically this situation would require that hospitals should be standardized after the same manner that medical schools of late years have been standardized, and that only such hospitals as came

up to the standard would be selected as interne hospitals. It was argued that hospitals that would be thus included in the adopted standards, would, in effect, be endorsed by the medical profession and the medical colleges of the country, and such endorsement would be of such great value as to warrant the changes in hospital administration and added facilities and equipment that would be required of most hospitals before they would be accredited as teaching and interne hospitals. It was very definitely pointed out by most of the speakers that it did not depend so much upon the number of beds in the hospital as it did upon their facilities for instruction—the two most important and required items being an extensive and up-to-date library and modern and properly equipped laboratories. It was argued that these untrained students were not presumed to be placed in the hospitals for doing the drudgery of such institutions, but that they might have the opportunity for clinical study and investigation, while, at the same time, giving valuable service to the institution.

Dr. Murphy, President of the A. M. A., declared that too much time was given in all medical schools to the teaching of principles and not enough time to the application of those principles. He declared that if the course of medical instruction was to remain at four years that at least one year of that time should be given over entirely to the work contemplated in the interne or hospital year. Most of the speakers agreed that the adding of this year was very much more important than to add any more requirements to the entrance; that the two years' college entrance requirements, or even less, was sufficient; but that the great need of American medical education was actual hospital experience, which so few are permitted to have.

In a questionnaire sent out to a large number of hospitals throughout the United States, having a hundred beds, or over, it was found that forty per cent. as I remember it, were at present equipped and conducted in a manner that would probably comply with the standards of an interne hospital. It was pointed out that the best of the European schools have had this hospital year requirement for a considerable length of time, although the years' work is not under the strict supervision that the American plan contemplates.

The necessity for an out-patient service with the hospital was emphasized and it is generally believed, judging from the remarks made in the lobbies, that this movement, which was so heartily endorsed, and I believe permanently started on its way, will revolutionize the hospitals work, the same as the Carnegie founda-

tion reports on the medical schools of the country has revolutionized and standardized those institutions.

The following day was taken up with medical and public health legislation, the Chairman of the Conference being Dr. Henry B. Favill of Chicago. Dr. Favill's address as Chairman, well nigh created a riot in the proceedings, or, at least, called forth some very heated discussions. Dr. Favill indicated that the physicians of the country should not as a profession, put any special pressure upon medical legislation—that it was the business of the organized profession, meaning the A. M. A., to educate the people in matters of public health and public welfare, so that, naturally, the proper legislation would be enacted by reason of an educated public opinion. Well, the way the doctors jumped onto that proposition was beautiful to behold! They declared it would be nothing short of a crime to at this time abandon their fight for the creation of a national department of health; that it would be a tacit acknowledgment of defeat; that it would leave the impression that the charges made by the League for Medical Freedom, were true, and that public health legislation would be set back half a century if we were to passively await the gladsome day when all the people would be educated to such a high standard as to take up active interest in public health legislation.

It is unnecessary to add that a resolution was offered strongly endorsing the action that the Association has hitherto taken in the matter of public health legislation, and re-affirming the demand that Senate Bill No. 1 should be passed.

After the Chairman's address the Committee on Resolutions and other committees were appointed, and the writer happened to be appointed on the committee on resolutions and had, therefore, the opportunity and the pleasure of voting for the resolution upholding the Association in its battle to protect the rights of the people, and demand legislation on matters of public health.

Dr. Wilbur's paper on Vital Statistics in the United States gave credit to Kansas as having a new vital statistics law which would ultimately admit her into the registration area.

The paper on the Essentials of State Legislation on Foods and Drugs by Prof. E. F. Ladd, commissioner of North Dakota, was frequently interrupted with generous and hearty applause. Among other things, Prof. Ladd advocated the creation by the Federal Government, or by each state, of a commission to which should be referred all formulas of patent medicines or other advertised nostrums, and that a license be required from the commission before such medicines would be permitted to be manufactured and sold.

The subjects of Railway Sanitation, Federal Inspection of Dairy Products and State and Municipal Health Officers, were ably discussed by specialists along those lines. Taken all together, the Conference was most instructive, illuminating and helpful.

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SOCIETY NOTES.

Following is the program of the Harvey County Medical Society for April.

"THE EYE."

"Relations of Iritis to Constitutional Diseases," Dr. S. S. Haury. Discussion, Dr. A. E. Smolt.

"Technique of Minor Surgery of the Eye," Dr. B. A. Countryman. Discussion Dr. J. L. Grove.

"Use and Abuse of Mydriatics," Dr. M. L. White. Discussion, Dr. S. S. Haury.

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At the Feburary meeting of the Barber County Medical Society, Dr. W. L. Welsh of Hazelton read a paper on Scarlet Fever, A Few Observations. Dr. O. A. Harmon read a paper on La Grippe, and Dr. J. J. Sippy, on Vital Statistics and the Care of Tuberculosis. The following officers were elected:

Dr. R. W. Coffee, Hardner, President; Dr. O. A. Harmon, Kiowa, vice-president; Dr. G. R. Waite, Kiowa, sec'y-treasurer; Dr. W. L. Welsh, delegate to the state society. Drs. Cloud, Stallard and Gilbert, censors.

After the meeting a banquet was held at which time there were fifty guests in attendance.

GEO. W. WAITE, Secretary.

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At the meeting of the Wyandotte County Medical Society held Tuesday, March 12, the following program was given:

SYMPOSIUM ON NEPHRITIS:

Anatomy, Physiology and Classification, Dr. Preston Sterrett.

Etiology and Pathology, Dr. H A. Nave.

Symptoms, Diagnosis and Treatment, Dr. Wm. F. Fairbanks.

The society is in better shape now than ever before. The membership has reached a total of 90, due largely to the efforts of the secretary, Dr. J. F. Hassig. This makes Wyandotte county the largest county society in the state.

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ANNUAL MEETING OF THE STATE SOCIETY AT HUTCHINSON, MAY 1--2.

The Sumner County Medical Society held a meeting at Wellington, April 4. The subject of the evening was "Education of the Public on Health Lines." The idea of the meeting was to have papers presented suitable for publication in the daily papers.

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THE NEMAHA COUNTY MEDICAL SOCIETY.

Centralia, Kans., Feb. 22, 1912.

The meeting was called to order by President Dr. W. G. Bouse.

Minutes of previous meeting read and approved.

Dr. C. R. Townsend read a paper on "Piles,". Discussed at length by all present. The author advocated the ligature as a curative measure.

Thorough dilatation of the sphincter, followed by the clamp and cautery, was the procedure of choice by most of the speakers.

The etiology and pathology were presented by Dr. S. H. Brown. The incipient condition he described as simply dilated veins, the result of partially obstructed portal circulation.

Dr. J. C. Maxson, from clinical notes presented the subject of puerperal eclampsia, and afterward closed the prolonged discussion by explaining the classic principles of treatment and his own particular and successful application of them. He emphasized the element of blood pressure as a cause of the convulsions. The address was concise and practical, founded on experience and a fundamental knowledge of the disease.

The secretary read a paper on "Blood Pressure," His thesis was that arterial hypertension should be regarded as a disease *per se*, till the cause of it—the underlying nature of the poison circulating in the blood—could be discovered.

That high pressure is a sufficient cause of arteritis, arterio sclerosis, all forms of Bright's disease, and many other incurable conditions, if the primary cause, usually discoverable, was not removed; that as a means of diagnosis the sphygmomanometer should be more used; that the immediate cause of puerperal convulsions was high pressure on the responsive nerve center; that the same were true of severe epileptic seizures, and that the prompt reduction of pressure would prevent the symptomatic convulsion.

Dr. Maxson reported a case of attempted suicide by swallowing a half ounce of carbolic acid, and the successful treatment with sulphate of magnesia, and repeated washings of the stomach with 25% solution of alcohol by means of the stomach tube-syphon.

The following resolutions were unanimously adopted:

First, All good physicians know that the advancement of Medical Science means the increased welfare of all of the people,

and of all governments, municipal, state and national; that the first essential of a good physician is high class citizenship, duly sensible of the heavy responsibility resting upon him, as an educated conservator of the morality, health and happiness of the people, and the sacred obligation to assume all such duties as will enable him to best serve the people, both in his professional and civic capacities; therefore,

Resolved, By the Nemaha County Medical Society of Kansas, in regular session assembled, That we endorse the candidacy of our honored member and officer of the Kansas Medical Society, Dr. Charles S. Huffman, for the office of Governor and that we pledge to him our loyal support regardless of political affiliations; all for the common good of Kansas.

(By Dr. J. H. BROWN.)

Second: Well knowing that there is a numerous nation-wide army of patent medicine grafters and impure food fiends, known as the League for Medical Freedom, who have duped into affiliation with them in their crusade of moral and commercial corruption other sectarian forces of medical practice, and the many cults of healing, and who are working together, have corrupted to a dangerous extent, the pulpit and the press; the state and national legislature, in their efforts to nullify the beneficence of the Pure Food and Drugs Act, who are hostile to all the blessings that state medicine has brought to the people, and would forbid all further efforts in that direction, therefore be it

Resolved, That we urge upon Congress the enactment of The Owen Bill, to create and maintain a Department of Health, to promote and protect the health of the people collectively and individually; and that we, as citizens, each write to our representatives and senators in Congress, requesting them to support the Owen Bill.

Third: Recognizing our efficient state Board of Health as a model for the country; that in common with our higher institution of learning, it returns many times ten-fold value to the state for every dollar it expends; that its members are faithfully and arduously performing a work of love and devotion for all the people, especially the unfortunate, an impressive example to all of us of professional and civic righteousness, therefore be it

Resolved, That we urge upon the legislature of Kansas, the high duty of generous appropriations to further its beneficient work; that we pledge ourselves to uphold, and work in harmony with it; and that we commend to the honor, respect and affection of the people its worthy and able secretary, Dr. S. J.

Crumbine, the honored Dean of our University Medical School.

Appreciating the substantial courtesy of its Centralia brethern, who made possible the interest and success of the meeting, the society adjourned at 6 p. m. to meet in Corning, March 21.

DR. W. G. BOUSE. N. HAYES.
President. Secretary.

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NEWS NOTES

ANNUAL MEETING AT HUTCHINSON, MAY 1-2. WILL YOU BE THERE?

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Dr. T. D. Blasdell of Garnett, who has been in partnership the past five years with his brother, Dr. G. A. Blasdell, has located in the New Commercial Building, Parsons, Kansas, where he will limit his practice to diseases of the eye, ear, nose and throat.

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Dr. J. E. Hawley, Mayor of Burr, Oak Kansas, and Miss Rella M. Lambert, also of Burr Oak, were recently united in marriage.

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Born, Clinton Robert Lytle, to Dr. and Mrs. C. R. Lytle, Durham, Kansas, March 15, 1912.

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International Congress on Hygiene an Demography.—This congress will hold its fifteenth annual meeting in Washington, D. C., from September 23 to 28, 1912. President Taft is honorary president of the congress, Dr. Henry Walcott is president, and Dr. John S. Fulton is secretary-general. In connection with the congress, and in buildings especially erected for the purpose in Potomac Park, there will be an exhibit on public health in charge of Dr. Joseph W. Schereschewsky, of the United States Public Health and Marine Hospital service. This exhibit will open early in September and will continue until after the congress.

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The Methodist Episcopal Church is building a splendid hospital in Kansas City, Kansas. It is to take the place of the old one and is named Bethany Methodist Hospital.

Five and a half acres of very high, sightly ground in the very heart of the city has been purchased and a five story structure consisting of a main building 156 feet by 60 and a Nurses Home 40 feet by 50.

It will accommodate two hundred beds. Has three general

and one eye and ear operating rooms. Several rooms, such as "Recovery," "Delivery," "Baby Room," "Sterilizing," "Anesthetizing," and others, that bear a vital relation to operations. The first floor of the main building is largely devoted to administration, the second, third and fourth to patients exclusively. The furnace room and laundry, occupy the basement and first story respectively of the annex, and the other four stories are the Nurses Home.

The City is making a nine acre park in front of the hospital site. When finished, this Hospital will be one of the choicest and best equipped in Greater Kansas City. The enterprise is being largely financed by the sale of rooms. J. A. Motter is the superintendent and Elizabeth J. Eason, superintendent of Nurses.

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REVEIWS.

Foreign Body in Bronchus.—E. C. Todd, Minneapolis, (Journal A. M. A., March 9), reports a case of bronchoscopy with removal of a brass thumb-tack with two sharp, crooked points. Tracheotomy had to be performed before the operation could be completed, but improvement occurred at once on removal of the foreign body. It is probable, he says, that the foreign body may have been lodged for a time in the larynx or at least, have produced sufficient trauma there, to account for the very noisy breathing of the patient and the necessity of tracheotomy. It also shows, Todd says, the advantages of an x-ray picture covering the whole respiratory region, which was unfortunately not obtained in this case, though the general result was good.

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Cerebrospinal Meningitis.—The recent discovery of the fact that the natural habitat of the organism of cerebrospinal meningitis is in the nose and throat is considered by H. T. King, New Orleans (Journal A. M. A., Feb. 10), to be the most important contribution to our knowledge of the prophylaxis of the disease. With this fact also should be considered the discovery that the disease is carried from individual to individual, often by healthy carriers. The theory of direct extension from the nose and throat to the brain is untenable. The blood-route must be the one followed. In many cases the organism has been found in the blood and it seems to have a special affinity for the meningeal tissues. There must, be however, some lowering of tissue resistance or increase of virulence of the organism, and the cause of this may, in some cases, be a trauma. The disease is undoubtedly trans-

mitted directly from individual to individual and the number of persons carrying the infection is much greater during an epidemic than the number of patients. King estimates that nearly one-fourth of all individuals of the infected locality may be carriers of the disease without apparently showing any serious symptoms. Only occasionally do they present signs of a nasal pharyngitis or slight meningococcal infection. There are some persons who probably carry the germs permanently and perpetuate the disease. Up to the present there has been no absolutely efficacious means of causing the disappearance of the germs in the carriers, but the rigid observance of certain precautions would limit the extent and severity of epidemics. The first essentials for this are: 1. The earnest co-operation between the people and the health authorities in enforcement of all necessary health regulations. 2. The detection and isolation of healthy germ carriers. 3. Efforts toward rendering them harmless. Thorough sanitary inspection is necessary and attention to soil pollution, especially in rural districts. Particular efforts should be made to destroy all germ-carrying parasites and vermin. Circulars of information should be distributed. School inspection should be thorough and popular lectures will also be useful. A carrier once recognized should be put under the care and observation of the health authorities and treatment directed toward disinfection of the nose and throat. All carriers should be inoculated with the anti-meningococcal serum. The results should be constantly tested bacteriologically and oral and nasal hygiene be made a routine, not only with them, but with others. Fomites, such as vessels, spoons, handkerchiefs, etc., which have become infected should be thoroughly sterilized or destroyed and special directions as to spitting, sneezing and coughing be given to all carriers of germs. By these means we may hope to minimize the effects of the disease when it occurs.

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Early Diagnosis of Gastric Ulcer.—Smith, in the American Journal of Obstetrics, insists that the diagnosis of chronic surgical lesions in the upper abdomen can be made with accuracy, in the great majority of instances, by the anamnesis alone. This differentiation can be strengthened frequently by the physical findings, and later receive confirmation from laboratory examinations. He further points out that the symptoms of diseases in the locality under consideration, as generally understood and as taught in the text books are often those of the terminal events or of complications. Of gastric ulcer, the author says it will be found that the symptoms have existed periodically for at least

months, or more often, years. At first only an immoderate meal provokes the stomach distress. Later the one hearty meal was followed by pain, while the others were not so attended. Still later all three meals provoke the distressing syndrome. The fact that stomach symptoms have existed for a long period should of itself suggest the possibility of ulcer. That these symptoms have recurred in periodic attacks emphasizes the probability of ulcer. This periodicity is the most striking feature in the history of ulcer. In these earlier attacks the patient has perfect ease after taking food lasting from one to two hours in gastric ulcer and from two to five hours in duodenal ulcer, which is followed by a sense of weight, fullness and oppression in the stomach, later ameliorated by sour ecutation and the expulsion of mouthfuls of sour vomitus. It would be more correct to speak of the pain as preceding and as being relieved by the meal. In duodenal ulcer the attacks are often in the night, awakening from sleep. Tenderness on pressure is, of course, found. In a subsequent time when the symptoms are really those of the complications the appetite becomes fickle and the patient denies himself food because of the distress occasioned. Hemorrhage sets in long after the diagnosis should have been established.—Medical Standard.

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Arteriosclerosis—Treatment of.—Dr. Beverly Robinson, of New York, states that the larger his experience and the more he watches cases of pronounced arteriosclerosis, especially in men and women past middle life, the less frequently does he prescribe either digitalis or the iodides. If a cardiac tonic or stimulant is required, strophanthus, caffeine, and nux vomica are preferable by far and are not liable, in small or moderate doses, to do positive injury. They require also judicious watching and suppression at times, but not to the same degree as digitalis. To lessen supertension, where it is clearly indicated by reason of headache, fainting attacks, pallor and general nervous irritability, sweet spirits of nitre in small or moderate doses, added to water, is the least injurious and most useful drug the author knows of, not excepting nitroglycerin and the nitrites. Supertension in arteries, like the physical changes upon which it depends and with which it is allied, is highly conservative and should not be combated by any unwise attempts to control or modify it. Important measures in the treatment are change of scene and occupation; fresh air, good diet; with limitation in the amount eaten daily; and avoidance of excess of meat, sweets, alcohol, sauces, fats, uncooked fruits, or vegetables; and abundance of water internally. Phy-

sical exertion should be moderate, the skin should be kept in good condition, and mild saline laxatives should be administered twice a week.—Journal of the New Jersey Medical Society.

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MISCELLANEOUS.

Do You Read Medical Journals.—This may on first thought seem an impertinent query. There are a great many physicians who do not read their current medical literature, and who are, incidentally, losers by not doing so. A traveling man recently remarked to the writer that he was often amazed when calling on physicians from day to day to find the stacks of medical journals on the office table with the covers still intact. Another traveling man said he not infrequently found the office waste basket teeming with unread journals. Is this the fault of doctors or of the journals to which they subscribe? We believe that it is mainly indifference on the part of the doctors. Many excuse their lack of interest in medical periodicals by asserting that they depend upon text-books and thus get their medical pabulum from a more authorative source. This sounds well, but do they always do it? We believe men who are too lazy to read the journals are likewise inclined to eschew a more ponderous volume. Even the writers of text-books are not infallible. Generally speaking, we know that wisdom and truth are bound up between their lids, yet not a few text-books are simply a revamp of old and well-worn ideas embellished by the author's point of view. Even the writers of books have been known to have a paucity of experience. And this is not to be construed toward the discouragement of the reading of books; too often our silent friends on the shelves have their leaves untarnished by acutal use. There may be rot in the pages and between the lines of the medical journals, but it has the advantage of being served up in small doses. Our best ideas and most recent discoveries usually find expression in the pages of the medical journals; the physician who ignores them is losing a golden opportunity. The journal can be carried anywhere so that literally he who runs may read. One medical man states that he always has a journal in his obstetric bag or overcoat pocket. Such an individual is seldom lacking in medical lore, and he usually has it, as it were, at his very finger tips. The physician who peruses a dozen medical journals for ten years can not otherwise than be the possessor of a vast amount of medical lore. Another thing, most of the articles contained in the medical magazines are of a practical trend and contain suggestions that

one may incorporate into his every day work. The doctor who is disposed to look upon medical articles from a highbrow standpoint and call them **punk** should try writing more himself, and see whether his endeavors are more illuminating and edifying. The effusions of the medical journal writers, even those of us exalted (?) editors, are not always marked by literary grace and appealing style, yet it is ever the aim to get down to business and offer thoughts that will in some manner prove helpful to the plodding physician. The doctor who permits his journals to sleep with their overcoats on is letting golden opportunitys go by.—Medical Summary.

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For Sale. Static Machine, Resonator, Wall Plate, 500 C. P. Leucodescent Lamp, Nebulizer, Victor Vibrator, Microscope, Yale Chair.—Gertrude Barnes, Topeka, Kans. Administratrix.

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The following from the Journal of the Indiana State Medical Society while not seen often in this day and age is worth reading.—

A young doctor tells us the following story which we think carries a lesson with it:

"For the last year I have practiced in ———, a small Indiana town surrounded by a fertile country inhabited by well-to-do farmers. I have had as a confrere, or rather a competitor, an old physician who practiced in the town for forty years. This old doctor did an enormous amount of work at charges ridiculously small, and a few months ago boasted that he had never sent a statement of account to any patron during the forty years of his practice. Recently the old doctor died, and in settling up his estate it was discovered that he had over $60,000 in book accounts, most of which are outlawed and not 10 per cent. of the balance of which are collectable. The old doctor's aged wife and an invalid daughter were left a comfortable home, but it was mortgaged for nearly as much as it was worth and so was not long retained. Therefore, almost at the date of the death of the old doctor, his wife and daughter were thrown on relatives and friends for their support. During the old doctor's life he lived frugally and had but little enjoyment aside from that found in his work. He never found time to take a vacation and seldom attended a medical society. He possessed few books, fewer instruments, and the only medical journals received gratuitously or through subscription usually were thrown away with their wrappers still on. He apparently was loved and respected by a large following, probably because of his good nature and kindly sympathy as well as his known habit of never asking for remuneration for services ren-

dered. He may have left an enduring monument in the questionable good done suffering humanity, but in my judgment his life was a failure and he did not live up to the demands of his position nor pay the debt he owed to those who depended on him. He owed more to himself, to his family and to his patrons than he made out of his life, and the community is the better without him unless the doctors who may follow him pursue a different course and the people learn to consider a doctor as something more than a being to be imposed on. But the influence of this old doctor who was uncouth, unbusiness-like and very uneducated according to present day standards, has been thoroughly demoralizing in every way and I have firmly decided that I haven't the time or patience to wait for the evolution which must take place before this community becomes a haven of refuge for any doctor who has intelligence, ambition and a natural tendency to progress. The atmosphere would shrivel the good qualities of any doctor who aspires to anything more than a monotonous and profitless existence, and I propose to leave the field to those doctors who are satisfied to exist rather than live. I am going to another community where I think the attitude of the people will encourage me to give them the best that is in me, where there is incentive to develop and progress, and where I shall receive adequate return for my labors. If I find that I am mistaken in my notion that men of my profession should be business men as well as doctors, and that they should receive enough for their labors to enable them to live rather than exist, then I shall take up another vocation, for I am dependent on my earnings to provide the comforts of life, and, if I practice medicine, to enable me to keep up my medical education so that it shall be abreast of the progress of the age."

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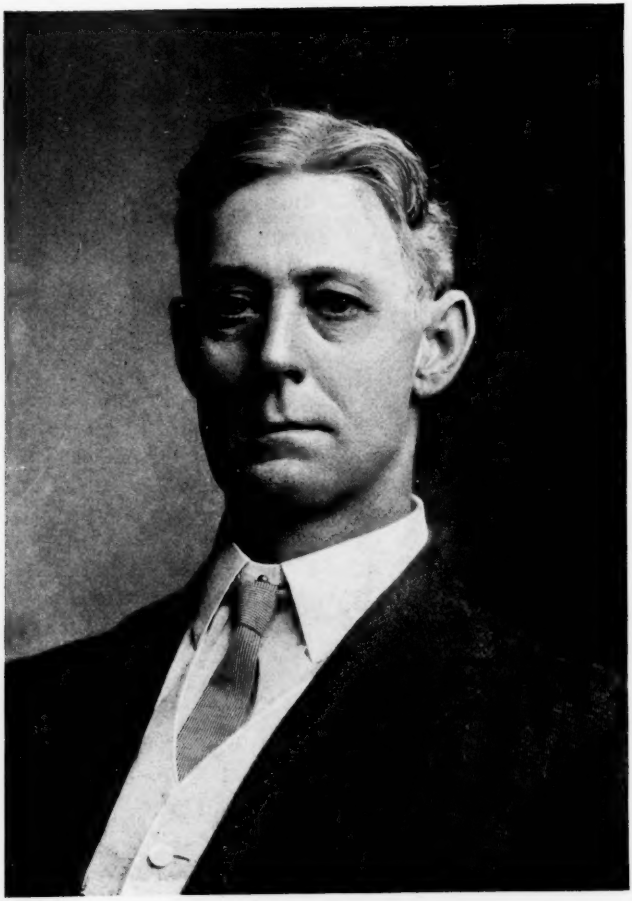
CLINICAL NOTES

The Nervous Patient.—It is occasionally the practice of physicians to try to persuade nervous patients that there is really nothing the matter with them. Such a course is the gravest folly, for it has but the effect of discouraging the patient (since he is certain that there is something the matter with him), and decreasing his confidence in his physician. He feels sick, and no amount of urging can persuade him to the contrary. Functional nervous disorders are just as definite as if they were organic. The sooner the practitioner recognizes that something definite is the matter, and finds out what it is, the quicker he may effect a cure.—W. L. Cowles in the New England Medical Monthly.



Geo. W. Gray

PRESIDENT KANSAS MEDICAL SOCIETY, 1912-13.